

# EpicCareLink New User Confidentiality Agreement

## Use EpicCareLink to access clinical information (i.e., lab results, transcriptions) for your patients that have been admitted to a Renown Hospital.

**\*\* Incomplete forms will not be processed. Forms take 5 business days to process. \*\***

I, \_\_\_\_\_ (*please print*), agree to handle all information obtained through the use of EpicCareLink with the utmost confidentiality. I understand that Renown Health is granting me access to Affiliate Link for the use in the course and scope of my employment. I also understand that Renown Health has assigned to me a user ID for the sole purpose of allowing me to access EpicCareLink. I understand that any negligent or intentional violation of this agreement or breach of patient confidentiality using information acquired through EpicCareLink will be cause for immediate termination of all system privileges and appropriate discipline pursuant to Renown Health policies and procedures. Furthermore, Renown Health shall take appropriate action to comply with any and all applicable federal, state and local laws and regulations regarding such a violation including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

### Password/User ID Terms of Use

- I agree to use my unique user ID and password only in the course and scope of my employment.
- I agree to safeguard my unique user ID and password.
- I agree that I will not leave any workstation unattended while being signed on to the system.
- I agree to use only my own user ID, and will not share my user ID and password with others.
- I will notify Renown Health promptly of all terminations and hiring of staff who use or need access to HealthConnect.

### Data/Patient Information

- I agree to comply with the applicable provisions of HIPAA and Renown Health policies and procedures related to HIPAA, patient privacy and Information Protection.
- I will not access patient or member data for any reason or purpose unrelated to my employment.
- If I believe that information security has been compromised, I will notify Renown Health immediately.
- I will not share the data obtained through EpicCareLink with any person, office or entity that does not contract directly with Renown Health for the services provided by this agreement.

User signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name & Title: \_\_\_\_\_ Initials required: POS1 \_\_\_\_ \_

Email: \_\_\_\_\_ Birthdate (month&day)\_\_\_\_/\_\_\_\_ Phone #:(\_\_\_\_)\_\_\_\_\_

Clinic/Office/Department Name **and** Tax Identification Number(s): \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Owner, Provider or Legal Representative)

Print Name & Title : \_\_\_\_\_ Phone #: (\_\_\_\_)\_\_\_\_\_

**Mail the complete, original agreement to: Renown Health IR**  
850 Harvard Way, Mail Code X14, Reno, NV 89502  
In lieu of mailing, fax the original to: 982.4513

**For Internal Use: Date Request Received** \_\_\_\_\_

Account Approved \_\_\_\_\_ Denied \_\_\_\_\_

User Name \_\_\_\_\_

Password \_\_\_\_\_

Information Protection: \_\_\_\_\_

Information Owner: \_\_\_\_\_